

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

April 26, 2011

Barbara Edwards, Director
Disabled & Elderly Health Program Group
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare & Medicaid Services
Attention: CMS-2337-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-2337- P

Proposed Rules Medicaid Program; Community First

Choice Option

Dear Ms. Edwards:

I am writing to you on behalf of Colorado's single state Medicaid agency, the Department of Health Care Policy and Financing to provide comment related to proposed rule CMS-2337-P Community First Choice Option under Section 2401 of the Affordable Care Act (ACA) of 2010.

Colorado shares the federal interest in furthering the provision of community-based services and expanding opportunities to do so under self-directed service delivery models, but wishes to ask for clarification on some provisions and to raise concerns about other provisions. In order, Colorado has these specific comments on the proposed regulations:

§441.500(b) Scope: Is there State flexibility to focus on a single modality (hands-on or supervision or cueing) or must all three modalities be covered?

§441.505 Definitions. Please add a definition for *Voucher*, as used in §441.545(b)(3).

§441.505 Definitions. Please clarify how the language specifying that *Health-related tasks* are tasks that can be delegated or assigned by licensed professionals might interact with a State statutory exemption from Nurse Practice Act delegation requirements for health maintenance activities under a Medicaid self-directed model. Is the State required to conform to the delegation expectation as defined? May a State operate more than one self-directed option under the different authorities of section 1915 where an item of specific difference is the delegation requirement?

§441.505 Definitions. *Individual's representative*. Please clarify whether a State may select a self-direction delivery model that limits direction by representatives, for example to parents of minor children. Also, please clarify whether a State may maintain existing state statutory prohibitions on a person serving as both a representative and as a paid attendant for the same client/beneficiary.

- 441.510(a) Eligibility. Please clarify whether this includes the Family and Children's and the Medicare savings eligibility categories.
- 441.510(b) Eligibility. Please clarify whether a State is required to cover <u>all</u> of the income options defined at (1), (2), and (3) or may a State limit eligibility to only one or two of the income options?
- 441.510(b)(2) and (3) Eligibility. Please clarify the differences in these two proposed eligibility groups. It is Colorado's understanding that there is not an eligibility group specific to waiver programs, rather Section 1902(a)(10(A)(ii)(V) of the Act allows individuals in institutions to be eligible under the 300% Special Income Group and Section 1902 (a)(10(A)(ii)(VI) of the Act allows for application of the 300% Special Income Group to those individuals receiving HCBS as an alternative to institutional care.
- §441.510 Eligibility. The stated criteria do not include a needs assessment element to focus participation. Since the services and supports in question are not medical, the universally implied Medicaid "medical necessity" standard is not appropriate. Colorado strongly recommends CMS consider adding a new eligibility element to allow for focusing participation to individuals who are assessed as having a need for attendant services. For example: §441.510 (d) Eligibility. Meets needs assessment criteria for participation that are approved in the State plan.
- §441.515 (c) Statewideness. The term "in a manner that provides the supports that the individual requires in order to lead an independent life" is very broad; may a State set some reasonable parameter on the level of support commitment such as an annual service budget amount limit or a cap on the hours of paid care per day?
- §441.515 Statewideness. Please clarify CMS expectations for reconciling 1915(c) authority focus where services & supports are intended as alternatives to institutional care and 1915(k) authority where supports are required to lead an independent life.
- §441.520 (a)(1) Required services. Is there state flexibility to focus on only a single modality (hands-on or supervision or cueing) or must all three modalities be covered?
- §441.520 (a)(3) Required services. The voluntary nature of training is contrary to Colorado's experience with ensuring individuals who self-direct have mastered the necessary skills to be successful. Colorado strongly recommends that training be a required step in demonstrating that the individual has the tools to select, manage and dismiss attendants.
- §441.520 (b)(1) Required services. If a State already covers transition costs in an HCBS 1915 (c) waiver may the transition benefit under Community First Choice Option (CFCO) differ? Or must the State be consistent? May the State limit the CFCO transition benefit to individuals not eligible for transition services under either an approved 1915 (c) waiver or under transition services funded through a Money Follows the Person (MFP) approved grant?
- §441.520 (b)(2) Required services. Will the SPA need to contemplate all potential supports/services that may be allowed in specific detail or may the SPA allow for categorizations? May the State define specific exclusions?
- §441.530 (e) Setting. Please clarify whether this exclusion applies to supported housing programs where housing and services are co-located to maximize clients' success in community living.

- §441.535 Assessment of need. Please clarify CMS' expectations about the face-to-face assessment process and instrument proposed for use in the Community First Choice Option and the more universal level of care (LOC) assessment and service planning process and instruments used in a State's HCBS 1915(c) waiver programs. Is there flexibility for a State to use the same fundamental processes & instruments but with different threshold levels for program participation or may a State choose different processes & instruments?
- §441.535 (b) Assessment of need. Please clarify that a State may set an assessment standard to operationalize the determination that an individual "requires the Community First Choice Option."
- §441.540 (a) Person-centered service plan. Please clarify whether a State may leverage existing single entry point entities currently under contract for HCBS 1915(c) waiver assessments and planning processes to conduct the planning process outlined in §441.540.
- §441.540 (a)(1) Person-centered service plan. Please clarify the apparent conflict between having necessary, appropriate and desired (by client) participation of family, etc. with the conflict of interest prohibition in §441.540 (c)(4).
- §441.540 (b) Person-centered service plan. Please clarify whether a State may use a prior authorization process to ensure services rendered and paid match the service needs identified through the service planning process.
- §441.540 (b)(6) Person-centered service plan. Please clarify "provider" that is required to sign the service plan. Is it the individual's attendants, the person responsible for conducting the service planning process, or the financial management entity responsible for paying attendants? If the intended provider is the attendant, please clarify whether each new attendant will be required to sign even if the service plan has not changed and is in effect for the full year.
- §441.540 (c)(4) Person-centered service plan. The prohibition on involvement of family, financially responsible parties, etc. appears to be in conflict with the requirements of §441.540 (a)(1) for the individual client to have participation of whomever the client chooses.
- §441.545 Service models. Please clarify whether a State may select a self-direction model under the authority of 1915 (k) that differs from its existing self-direction delivery models under HCBS 1915(c) waivers. Please also clarify whether CMS perceives any difference in self-direction delivery models approved under different federal authorities to be vulnerable to allegations of inequitable access under provisions of the Americans with Disabilities Act (ADA).
- §441.545 (b)(1) Service models. Please clarify expectations about payment methodologies for payments to the financial management entity. May payment be based upon a contingency fee percentage of an individual's service budget? May payment be tiered? Are such payments considered administrative costs and therefore limited to 50% FFP?
- §441.545 (b)(2) Service models. Please clarify when FFP is drawn under the direct cash option and how unexpended portions of a cash disbursement should be treated.

§441.545 (b) Service models. Please clarify whether a State may limit participation in self-directed models to individual clients or must the state allow authorized representatives to direct care on behalf of clients? If the option of an authorized representative to direct care must be included, please clarify whether existing State statutory safeguards that prohibit an authorized representative from also providing attendant services to the same individual client may be retained.

§441.545 (b)(3) Service models. Vouchers. Please add a definition of voucher to §441.505.

§441.550 Service plan requirements for self-directed model with service budget. Please clarify whether the State is allowed to set parameters or limits on any of the following:

- Annual service budget limit;
- Number of paid attendant care hours received from any single family member within a time period (per week, month, etc.)
- Wage maximum.

§441.550 (e) Service plan requirements for self-directed model with service budget. Please clarify whether the State is allowed to set parameters or limits on the amount to be paid for a service, support, or item.

§441.555 (b) Support system. Please consider giving States the option to make self-directed training mandatory to ensure that individuals have mastered the skills needed to manage the services and budget.

§441.555 (b)(2)(xiv) Support system. Please clarify whether the State's obligation is limited to providing information about existing advocacy systems or whether there is an expectation that the State actively invest in fostering development of advocacy systems for the Community First Choice Option.

§441.560 Service budget requirements. Please clarify whether a State may set a per person service budget limit for the self-directed model.

§441.560 (b)(1) Service budget requirements. Please clarify the applicability of "evidence based" to a service budget allocation methodology.

§441.560 (b)(1) Service budget requirements. Please clarify whether the "cost data" invokes a relationship to historical Medicaid rates and corresponding expenditure costs or if it CMS' expectation that "cost" is related to audited costs for providing services unrelated to historical reimbursement rates.

§441.560 (b)(1) Service budget requirements. Please clarify the test against which CMS will measure service budget allocation methodology to determine approval; is there an expectation of actuarial soundness or some other rate setting standard against which the methodology will be judged?

§441.560 (c) Service budget requirements. Please clarify CMS' intent around anticipated safeguards, and whether it is limited to circumstances when an individual's needs change and the processes to address those changed needs.

§441.560 (c) Service budget requirements. Please clarify whether a State may set participation parameters such that individuals may be prohibited from participating if client choices around wage limits result in the service budget being insufficient to cover the assessed needs.

- §441.565 (b) Provider qualifications. Please clarify whether a State, in accordance with state law, may prohibit family members from serving as the client's representative while also providing paid attendant services.
- §441.565 (b) Provider qualifications. Please clarify whether a State may set limits on the number of paid attendant care hours an individual may receive from any single family member, such as 40 hours per week.
- §441.565 (b) Provider qualifications. Please confirm the applicability of 42 CFR§ 440.167 that prohibits FFP for payments to legally responsible individuals for the provision of State plan personal care services unless the those services meet criteria as being "extraordinary" care.
- §441.570 (a) State assurances. Please clarify whether the maintenance of effort (MOE) is applied to only attendant services and supports and their equivalents or if the MOE is applied to all services that might be provided under the specified authorities.
- §441.570 (c)(3) State assurances. Please clarify which entity is expected to maintain general liability insurance; is it the individual who is self-directing care, the attendant providing services, or the financial management entity?
- §441.570 (c) State assurances. Please clarify whether the attendants' employer must provide those workers with health insurance coverage.
- §441.575 (a) Development and Implementation Council. Colorado notes a grammatical error in the repeated use of "primarily."
- §441.575 (a) Development and Implementation Council. Please confirm if a State may use an existing self-directed care advisory council or whether the requirement is for a dedicated advisory council limited to self-direction pursued under section 1915(k) authority.
- **§441.580 Data collection.** Please clarify anticipated mechanisms to report annual estimates; will CMS make changes to the CMS 37, the CMS 64 and MSIS to facilitate incorporation of these reporting requirements?
- §441.580 (a) Data collection. Please clarify any CMS expectations to reconcile estimated number of individuals anticipated to receive services against actual utilization. Will there be an expected accuracy standard; since this is a new option there is potential for significant discrepancy.
- §441.580 (c) Data collection. Please clarify whether self-report is an acceptable standard for type of disability, education level and employment status. Please also clarify the acceptability of retaining the original data with updates if there are any changes rather than collecting it each year.
- §441.580 (d) Data collection. Please clarify both the timeframe for data collection, such as previous fiscal year, and whether a State may limit the number of individuals reported to those who received attendant support services under the specified authorities, rather than all individuals served under the waivers.
- §441.580 (d), (e), (f) and (g) Data collection. Please clarify CMS expectations for linking these data; may a State begin with the data unlinked and phase in those capabilities over time?
- §441.585 Quality assurance system. Colorado shares CMS' interest in ensuring the quality of long term services and supports but is concerned about the complexity of the proposed quality assurance system. The

system proposed here is very similar to that for HCBS 1915(c) waiver programs, to which the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the National Association of State United for Aging and Disabilities (NASUAD) had the following commentary to Barbara Edwards on January 19, 2011.

The growing demands on states to implement increasingly complex quality management systems and improvement strategies are problematic because they: (a) deviate significantly from the original intent of the quality initiative, i.e. that CMS would review state systems of quality rather than monitor activities at the level of the individual beneficiary, (b) extend beyond the expectation specific in the HCBS Waiver Application Version 3.5 and related guidance, and (c) are being placed on states at a time when their fiscal and human resourced are diminishing.

§441.585 (b) Quality assurance system. Please clarify expectations for incorporation of stakeholder feedback that may conflict with federal regulations, State policy direction as defined in state statute, or drive increased expenditures for which a State lacks funding appropriation.

§441.590 Increased Federal financial participation. Please clarify CMS expectations on how these services and expenditures are to be tracked to appropriately draw the higher FMAP; will CMS revise the CMS 64 to reflect this state plan option?

Questions that may not relate to a specific regulatory cite:

- May a state run more than one self-directed program under different authorities such as 1915(c) waiver, 1915(i) SPA option and 1915(k)? If so, may these different authorities and options be more tailored to the expected enrolled population? Please also clarify whether CMS perceives any difference in self-direction delivery models approved under different federal authorities to be vulnerable to allegations of inequitable access under provisions of the Americans with Disabilities Act (ADA).
- Do payments made under 1915(k) have to be made via the Medicaid Management Information System (MMIS)?
- May the State include a mechanism whereby individuals may be disenrolled from the Community First Choice Option for cause such as not managing to the self-directed service budget?
- When State budget actions result in changes to provider reimbursement and service budgets under the Community First Choice Option (CFCO), please clarify expectations for what type of notice is appropriate. Does CMS consider such statewide changes to comport with changes to payment requiring public notice according to 42 CFR §447.205 or does CMS consider such statewide change implemented in CFCO service budgets to comport with appealable actions in accordance with 42 CFR §431 Fair Hearing for Applicants and Recipients?
- Please clarify the applicability of 42 CFR §440(d) authority that allows the Single State Medicaid Agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Thank you for the opportunity to provide comment and ask for clarification. Should you have any questions, I can be reached at <u>Barbara.prehmus@state.co.us</u> or via telephone at (303) 866-2991.

Sincerely,

Barbara B. Prehmus, M.P.H. Federal Policy & Rules Officer

Cc: Ms. Susan E. Birch, MBA, BSN, RN, Executive Director

Ms. Lorez Meinhold, Deputy Policy Director, Governor's Office of Policy and Initiatives,

Colorado Governor John W. Hickenlooper.

Ms. Cynthia Mann, Center for Medicaid, CHIP, Survey & Certification

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